ACTION PLAN

(To be completed by pediatric health professional and signed by parent)

Date:
Child's Name:
Medical condition(s) of concern:

Signs or symptoms to watch for: Treatment or Modification of Environment:
Note: When possible, please reduce or eliminate medication administration in the child care setting

Medication(s) (if applicable)			
Dosage(s)			
Time(s) of Administration			
Dates of Administration			
Possible Side Effects			

_____ _____
Pediatric Health Professional Signature **Phone**

I hereby give permission for the child care provider to administer medication as prescribed above. I also give permission for the child care provider to contact the prescribing pediatric health professional regarding the administration of this medication if there are problems or questions.

_____X_____
Parent or Guardian Name (Print) **Parent/Guardian Signature**

If the recommended steps above do not help my child, please call me immediately. If you cannot reach me in a timely manner, please activate the emergency medical services.

Parent/Guardian Contact Info:

Home Phone **Work Phone** **Cell Phone**
Pager

As the parent/guardian, I will, in writing, keep the program informed of any change to my phone numbers.

_____
Parent/Guardian Signature

RELEASE OF LIABILITY

I hereby release and forever discharge Child Development and Youth Programs and its employees or agents from any and all liability arising in law or equity as a result of administering any medication or treatment authorized above. This waiver and release of liability includes, but is not limited to, claims, actions, expenses, damages, injury, death, loss or damage to material and/or equipment supplied by the parent(s)/guardian(s), in any way relating to the administration of medication or treatment.

Parent/Guardian Signature

Date